FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

I. IDPH Facility ID Number: 0044792

Facility Name: Villa Scalabrini Nursing & Rehab

Address: 480 North Wolf Road (Number) Northlake (City) 60164 (Zip Code)

County: Cook

Telephone Number: (708) 562-0040 **Fax #** (708) 562-3955

HFS ID Number: 237061646008

Date of Initial License for Current Owners: 03/01/2000

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 (c)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 634-4581
Please send copies of desk review and audit adjustments to address on this page.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2005 to 06/30/2006 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 384-6000 Fax # (312) 634-5518

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds April 10, 2006

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	144	Skilled (SNF)	154	53,380	1
2		Skilled Pediatric (SNF/PED)			2
3	82	Intermediate (ICF)	82	29,930	3
4		Intermediate/DD			4
5	33	Sheltered Care (SC)	17	10,733	5
6		ICF/DD 16 or Less			6
7	259	TOTALS	253	94,043	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	19,851	8,403	10,751	39,005	8
9	SNF/PED					9
10	ICF	23,379	14,243		37,622	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,230	22,646	10,751	76,627	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.48%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/01/2000

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/01/2000 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 34 and days of care provided 10,751

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/06 Fiscal Year: 06/30/06

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	524,274	57,855	565	582,694		582,694		582,694			1
2	Food Purchase		415,093		415,093		415,093	(12,585)	402,508			2
3	Housekeeping	274,624	31,730	543	306,897		306,897		306,897			3
4	Laundry	136,908	46,206		183,114		183,114		183,114			4
5	Heat and Other Utilities			447,504	447,504		447,504		447,504			5
6	Maintenance	147,221	19,065	214,501	380,787		380,787		380,787			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,083,027	569,949	663,113	2,316,089		2,316,089	(12,585)	2,303,504			8
	B. Health Care and Programs											
9	Medical Director			13,500	13,500		13,500		13,500			9
10	Nursing and Medical Records	4,565,644	298,721	21,660	4,886,025		4,886,025	10,170	4,896,195			10
10a	Therapy	261,176	3,232	13,109	277,517		277,517		277,517			10a
11	Activities	164,712	7,982	7,627	180,321		180,321		180,321			11
12	Social Services	110,267	662	473	111,402		111,402		111,402			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	5,101,799	310,597	56,369	5,468,765		5,468,765	10,170	5,478,935			16
	C. General Administration											
17	Administrative	118,383		954,261	1,072,644		1,072,644	(954,261)	118,383			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			8,877	8,877		8,877		8,877			20
21	Clerical & General Office Expenses	463,743	51,894	35,733	551,370		551,370	734,344	1,285,714			21
22	Employee Benefits & Payroll Taxes			2,260,337	2,260,337		2,260,337	396,892	2,657,229			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,008	2,008		2,008		2,008			24
25	Other Admin. Staff Transportation			1,952	1,952		1,952		1,952			25
26	Insurance-Prop.Liab.Malpractice			134,054	134,054		134,054	15,030	149,084			26
27	Other (specify):*											27
28	**TOTAL General Administration**	582,126	51,894	3,397,222	4,031,242		4,031,242	192,005	4,223,247			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,766,952	932,440	4,116,704	11,816,096		11,816,096	189,590	12,005,686			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

****See schedule of adjustments attached at end of cost report.**

Facility Name & ID Number Villa Scalabrini Nursing & Rehab #0044792 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			361,736	361,736		361,736	52,571	414,307			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			16,568	16,568		16,568		16,568			35
36	Other (specify):*											36
37	TOTAL Ownership			378,304	378,304		378,304	52,571	430,875			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,294,372		1,294,372		1,294,372		1,294,372			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			125,655	125,655		125,655		125,655			42
43	Other (specify):* Nonallowable Cost			3,066	3,066		3,066	(3,066)				43
44	TOTAL Special Cost Centers		1,294,372	128,721	1,423,093		1,423,093	(3,066)	1,420,027			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,766,952	2,226,812	4,623,729	13,617,493		13,617,493	239,095	13,856,588			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(12,585)	2		4
5	Telephone, TV & Radio in Resident Rooms	(684)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(38,745)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	86,564			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 34,550		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	204,545		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 204,545		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 239,095		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Villa Scalabrini Nursing & Rehab

ID# 0044792

Report Period Beginning: 07/01/2005

Ending: 06/30/2006

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Post Additional Pension Expense	$ 79,775	22	1
2	Offset miscellaneous revenue against related expense	(5,175)	21	2
3	Disallow non-allowable advertising expense	(3,066)	43	3
4	Malpractice Insurance Expense Adjustment	15,030	26	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	86,564		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 **Report Period Beginning:** 07/01/2005 **Ending:** 06/30/2006

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(12,585)	0	0	0	0	0	0	0	0	0	0	(12,585)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(12,585)	0	0	0	0	0	0	0	0	0	0	(12,585)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	10,170	0	0	0	0	0	0	0	0	0	10,170	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	10,170	0	0	0	0	0	0	0	0	0	10,170	16
	C. General Administration													
17	Administrative	0	(954,261)	0	0	0	0	0	0	0	0	0	(954,261)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(5,859)	740,203	0	0	0	0	0	0	0	0	0	734,344	21
22	Employee Benefits & Payroll Taxes	79,775	317,117	0	0	0	0	0	0	0	0	0	396,892	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	15,030	0	0	0	0	0	0	0	0	0	0	15,030	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	88,946	103,059	0	0	0	0	0	0	0	0	0	192,005	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	76,361	113,229	0	0	0	0	0	0	0	0	0	189,590	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 **Report Period Beginning:** 07/01/2005 **Ending:** 06/30/2006

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(38,745)	91,316	0	0	0	0	0	0	0	0	0	52,571	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(38,745)	91,316	0	0	0	0	0	0	0	0	0	52,571	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(3,066)	0	0	0	0	0	0	0	0	0	0	(3,066)	43
44	**TOTAL Special Cost Centers**	(3,066)	0	0	0	0	0	0	0	0	0	0	(3,066)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	34,550	204,545	0	0	0	0	0	0	0	0	0	239,095	45

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Resurrection Health Care	100	See attached		See attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Nursing supplies	$	Resurrection Health Care	100.00%	$ 10,170	$ 10,170	1
2	V	21	Other admin & general		Resurrection Health Care	100.00%	408,388	408,388	2
3	V	21	Clerical & data processing		Resurrection Health Care	100.00%	331,815	331,815	3
4	V	22	Employee benefits		Resurrection Health Care	100.00%	317,117	317,117	4
5	V	30	Depreciation		Resurrection Health Care	100.00%	91,316	91,316	5
6	V								6
7	V	17	Intercompany expense	954,261	Resurrection Health Care	100.00%		(954,261)	7
8	V	39	Intercompany pharmacy	1,294,372	Resurrection Health Care	100.00%	1,294,372		8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,248,633			$ 2,453,178	$ * 204,545	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	See attached pg. 7A										2
3											3
4											4
5	Sister Elizabeth Trembczynski	Director	Board of Directors	0.00	107,120	<1 hour	<1%	N/A	N/A	N/A	5
6											6
7											7
8											8
9	Note: Sister Trembczynski is administrator of Holy Family Nursing & Rehabilitation Center, a related facility.										9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2005 Ending: 6/30/2006

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Resurrection Health Care/Medical Center
Street Address: 7435 W. Talcott
City / State / Zip Code: Chicago, IL 60631
Phone Number: ((773) 774-8000
Fax Number: ((773) 594-7488

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing supplies				$	$		$ 10,170	1
2	21	Other admin & general							408,388	2
3	21	Clerical & data processing							331,815	3
4	22	Employee benefits							317,117	4
5	30	Depreciation							91,316	5
6										6
7	39	Intercompany Pharmacy							1,294,372	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 2,453,178	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2	N/A											2
3												3
4												4
5												5
	Working Capital											
6												6
7	N/A											7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11	N/A											11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Villa Scalabrini Nursing & Rehab **#** 0044792 **Report Period Beginning:** 07/01/2005 **Ending:** 06/30/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2005 report.	***Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2001	8
	2002	9
	2003	10
	2004	11
	2005 N/A	12

This facility is a not-for-profit and does not pay real estate tax.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2005	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Villa Scalabrini Nursing & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044792

CONTACT PERSON REGARDING THIS REPORT Thomas W. Groenwald

TELEPHONE (773) 594-7837 FAX #: (773) 594-5867

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.		N/A	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not comsidered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 195,174 B. General Construction Type: Exterior Brick Frame Steel/Concrete Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	696,960	2000	$ 1,500,000	1
2					2
3	TOTALS	696,960		$ 1,500,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	259		2000		$ 7,510,695	$ 250,712	35	$ 214,591	$ (36,121)	$ 1,567,048	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Illuminated display sign			2000	9,374	937	20	469	(468)	2,814	9
10	Redecorating			2001	6,181	618	10	618		2,165	10
11	Sign			2001	6,805	681	20	340	(341)	2,040	11
12	Roof repair			2001	4,246	425	20	212	(213)	1,272	12
13	Condensor			2000	2,185	312	20	109	(203)	654	13
14	Monitoring system			2000	1,592	227	20	80	(147)	480	14
15	Refrigeration service			2001	1,650	236	20	83	(153)	496	15
16	Air conditioning repair			2001	576	82	20	29	(53)	145	16
17	Display			2001	1,629	233	20	81	(152)	405	17
18	Kitchen floor			2002	625	89	20	31	(58)	155	18
19	Air conditioning repair			2002	744	106	20	37	(69)	185	19
20	Electrical wiring			2002	1,000	143	20	50	(93)	250	20
21	Roof repair			2001	614	61	20	31	(30)	155	21
22	Illuminated display			2001	4,199	420	20	210	(210)	1,050	22
23	Renovations			2002	2,385	238	20	119	(119)	595	23
24	Canopy			2002	2,100	210	20	105	(105)	525	24
25	Sewer line			2002	4,200	420	20	210	(210)	1,050	25
26											26
27											27
28	Reclass from moveable equipment:										28
29	Replace 20-ton Trane compressor			2002	7,791	779	10	779		2,727	29
30	Rewiring of emergency nurse call			2003	6,995	700	10	700		2,450	30
31	Patch foundation wall at handicap ramp			2003	19,850	1,323	15	1,323		4,631	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Door openers	2003	$ 7,876	$ 788	10	$ 788	$	$ 1,970	37
38	Replacement-Expansion joints	2003	14,347	1,435	10	1,435		3,587	38
39	Fiber optic system upgrade	2003	9,343	1,869	5	1,869		4,670	39
40	South wing renovation	2004	23,112	1,156	20	1,156		2,890	40
41	Replace drain pipes	2004	5,092	339	15	339		848	41
42	Corridor carpet	2004	2,128	142	15	142		355	42
43	Pressure guages (4)	2004	8,851	1,770	5	1,770		4,425	43
44	Bumper guards	2004	2,392	239	10	239		599	44
45	Network closet - Dietary	2004	5,761	230	25	230		575	45
46	Nurses call station	2004	56,946	5,695	10	5,695		14,237	46
47									47
48	Sealcoat, crack fill & repair parking lot	2005	6,784	678	10	678		1,017	48
49	Carpet & installation	2005	2,128	426	5	426		639	49
50	Remodel Central Supply room	2005	1,928	241	8	241		361	50
51	Replacement of broken roof & barrel tiles	2005	17,026	1,703	10	1,703		2,554	51
52	Alternating Low Air Loss system	2005	26,120	1,741	15	1,741		2,612	52
53	Category 5E cable run for central supply room	2005	1,190	119	10	119		178	53
54	Ceramic tile & installation in smoking area	2005	3,950	263	15	263		395	54
55	Duct work for air conditioner run in laundry	2005	2,800	280	10	280		420	55
56	Fire protection system addition	2005	1,735	116	15	116		174	56
57	Roller latched for Units A & B	2005	7,828	783	10	783		1,174	57
58	Reflective tempered insulation	2005	2,929	366	8	366		549	58
59	Trane Compressors (2)	2005	862	172	5	172		186	59
60	Trane air conditioners (2)	2005	8,620	862	10	862		934	60
61	Entry door system	2005	4,260	852	5	852		923	61
62	Emergency lighting, phones system for elevators	2005	6,312	789	8	789		855	62
63									63
64	Signage installation	2006	2,516	252	5	252		252	64
65	Install amp circuits	2006	8,444	281	15	281		281	65
66	Replacement Pumps	2006	2,843	142	10	142		142	66
67	Install four voice cables	2006	4,154	297	7	297		297	67
68	Connect new storm line	2006	7,500	375	10	375		375	68
69	Install guardrails	2006	15,120	504	15	504		504	69
70	TOTAL (lines 4 thru 69)		$ 7,866,333	$ 283,857		$ 245,112	$ (38,745)	$ 1,640,270	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,866,333	$ 283,857		$ 245,112	$ (38,745)	$ 1,640,270	1
2	Knee walls improvement	2006	4,900	163	15	163		163	2
3	Oak Door	2006	1,644	55	15	55		55	3
4	Water softner system	2006	7,157	447	8	447		447	4
5	Replace baffle tile and refractory	2006	5,513	276	10	276		276	5
6	Drain pans	2006	7,510	376	10	376		376	6
7	Generator repairs	2006	4,705	235	10	235		235	7
8	Boiler repairs	2006	9,950	498	10	498		498	8
9	Asbestos removal - Steam Pipe	2006	2,725	91	15	91		91	9
10	Modify High Pressure Piping	2006	7,680	384	10	384		384	10
11	South wing renovation	2006	1,572,607	34,386	20-25	34,386		34,386	11
12	Survey & Removal of Asbestos	2006	133,728	2,727	25	2,727		2,727	12
13	Geotechnical Investigation	2006	3,071	61	25	61		61	13
14	Borger Responder IV Nurse Call System	2006	48,550	970	25	970		970	14
15	Remodeling Unit A	2006	17,500	525	15	525		525	15
16	Modify Exhaust Fan System	2006	2,085	104	10	104		104	16
17	Tile and floor base for Unit D	2006	1,600	53	15	53		53	17
18	Battery Powered Emergency Lights	2006	6,620	331	10	331		331	18
19	Repipe water lines for new controller	2006	1,951	65	15	65		65	19
20	Private office renovation	2006	1,443	103	7	103		103	20
21	Remove door guards from all doors in Units B,C,D	2006	2,700	135	10	135		135	21
22	Spence Valve thermostat	2006	2,650	133	10	133		133	22
23	Carpet & Vinyl base for Unit A corridor	2006	18,550	927	10	927		927	23
24	2 Steam bundles for hot storage tank	2006	10,700	535	10	535		535	24
25	Furnish & Install north & south dock doors in Dietary	2006	5,808	194	15	194		194	25
26	Locate leak in underground piping	2006	1,531	153	5	153		153	26
27	2 - 25mpc100, heavy duty self priming	2006	16,877	563	15	563		563	27
28	Install 2 steam bucket traps in tunnel for heat	2006	1,773	59	15	59		59	28
29	Doors & frames for receiving area	2006	9,356	311	15	311		311	29
30	Faucets	2006	6,560	328	10	328		328	30
31	Install new modified Bitumen	2006	2,300	115	10	115		115	31
32	Universal 25-27" TV wall mounts	2006	969	48	10	48		48	32
33	Fire Alarm	2006	1,650	41	20	41		41	33
34	TOTAL (lines 1 thru 33)		$ 9,788,696	$ 329,249		$ 290,504	$ (38,745)	$ 1,685,662	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,788,696	$ 329,249		$ 290,504	$ (38,745)	$ 1,685,662	1
2									2
3	Home Office Allocation					91,316	91,316		3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,788,696	$ 329,249		$ 381,820	$ 52,571	$ 1,685,662	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 240,060	$ 20,451	$ 20,451	$	5-15	$ 59,941	71
72	Current Year Purchases	258,634	12,036	12,036		8-15	12,036	72
73	Fully Depreciated Assets	1,853,924					1,853,924	73
74								74
75	TOTALS	$ 2,352,618	$ 32,487	$ 32,487	$		$ 1,925,901	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	N/A			$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 13,641,314	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 361,736	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 414,307	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 52,571	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,611,563	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2007	$
13.	/2008	$
14.	/2009	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ $16,568 Description: Security Carts - 144, Copier - 4,948, Medical Eqpt. - 8,617, Maintenance Eqpt. - 1,663, Dietary Eqpt. - 1,196
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$ N/A	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A (1,2,3)	3526 hrs	$ 105,035	88	$ 4,704	$ 499	3,614	$ 110,238	1
2	Licensed Speech and Language Development Therapist	10A (1,2,3)	503 hrs	18,091	94	4,057	512	597	22,660	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A (1,2,3)	4642 hrs	138,050	101	4,348	2,221	4,743	144,619	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				1,294,372		1,294,372	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 261,176	283	$ 13,109	$ 1,297,604	8,954	$ 1,571,889	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 **Report Period Beginning:** 07/01/2005 **Ending:** 06/30/2006

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2006 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,011,395	$ 1,011,395	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,305,918)	1,889,901	1,889,901	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,634	7,634	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,908,930	$ 2,908,930	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,500,000	1,500,000	13
14	Buildings, at Historical Cost	9,581,131	9,459,832	14
15	Leasehold Improvements, at Historical Cost	23,837	328,864	15
16	Equipment, at Historical Cost	2,536,346	2,352,618	16
17	Accumulated Depreciation (book methods)	(3,650,309)	(3,611,563)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	78,000	78,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(75,400)	(75,400)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Brosato Museum	297,647	297,647	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 10,291,252	$ 10,329,998	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 13,200,182	$ 13,238,928	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 127,030	$ 127,030	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to related parties	3,368,249	3,368,249	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,495,279	$ 3,495,279	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,495,279	$ 3,495,279	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 9,704,903	$ 9,743,649	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 13,200,182	$ 13,238,928	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 9,476,092	1
2	Restatements (describe):		2
3			3
4	**Prior Period Adjustment**	8,978	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 9,485,070	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	219,833	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 219,833	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 9,704,903	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,294,190	1
2	Discounts and Allowances for all Levels	(4,712,495)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,581,695	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,070,993	6
7	Oxygen	27,578	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,098,571	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	12,585	14
15	Telephone, Television and Radio	684	15
16	Rental of Facility Space	16,215	16
17	Sale of Drugs	1,533,267	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	9,301	20
21	Other Medical Services	498,686	21
22	Laundry	74,329	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,145,067	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,220	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,220	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	6,773	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,773	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,837,326	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,316,089	31
32	Health Care	5,468,765	32
33	General Administration	4,031,242	33
	B. Capital Expense		
34	Ownership	378,304	34
	C. Ancillary Expense		
35	Special Cost Centers	1,297,438	35
36	Provider Participation Fee	125,655	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,617,493	40
41	**Income before Income Taxes (line 30 minus line 40)****	219,833	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 219,833	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Villa Scalabrini Nursing and Rehab
Facility ID#: 0044792
7/01/05-06/30/06

Schedule 19A

XVII - Income Statement: Line 22 - Laundry

NOTE: Laundry revenue is generated from charges to private pay residents located in the facility, therefore it has not been offset against related expenses.

XVII - Income Statement: Line 28 - Other Revenue

Vending Commission	1,598
Miscellaneous	5,175
	6,773

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,864	2,080	$ 89,071	$ 42.82	1
2	Assistant Director of Nursing	1,832	2,080	68,516	32.94	2
3	Registered Nurses	55,067	59,811	1,863,385	31.15	3
4	Licensed Practical Nurses	17,738	19,609	460,823	23.50	4
5	CNAs & Orderlies	134,741	148,949	1,969,837	13.22	5
6	CNA Trainees					6
7	Licensed Therapist	7,917	8,671	261,176	30.12	7
8	Rehab/Therapy Aides	6,867	8,027	105,220	13.11	8
9	Activity Director	1,751	1,967	39,353	20.01	9
10	Activity Assistants	11,644	12,497	125,359	10.03	10
11	Social Service Workers	6,291	6,995	110,267	15.76	11
12	Dietician	2,988	3,176	64,478	20.30	12
13	Food Service Supervisor	2,191	2,586	55,749	21.56	13
14	Head Cook	8,778	9,490	124,902	13.16	14
15	Cook Helpers/Assistants	27,810	29,930	279,145	9.33	15
16	Dishwashers					16
17	Maintenance Workers	7,992	8,718	147,221	16.89	17
18	Housekeepers	24,399	26,791	274,624	10.25	18
19	Laundry	13,592	14,602	136,908	9.38	19
20	Administrator	1,824	2,080	118,383	56.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	23,077	25,523	463,743	18.17	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	447	503	8,792	17.48	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	358,810	394,085	$ 6,766,952 *	$ 17.17	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	4	$ 203	1(3)	35
36	Medical Director	Monthly	13,500	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	9	473	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	13	$ 14,176		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	16	$ 848	10(3)	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	16	$ 848		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jim Kouzios	Administrator	0	$ 118,383
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 118,383

B. Administrative - Other

Description	Amount
Management Fees	$ 954,261
(Eliminated on Sch. V, Line 17, Col. 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 954,261
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
None		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 85,136
Unemployment Compensation Insurance	15,774
FICA Taxes	481,035
Employee Health Insurance	1,210,036
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	12,810
Employee Dental Insurance	37,245
Employee Group Disability	21,395
Employee Retirement Plan	454,700
Employee Morale & Other Benefits	21,981
Home Office Allocation	317,117
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,657,229

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,496
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Life Services Network of Illinois dues	4,965
ACHCA membership dues	255
Miscellaneous dues & subscriptions	2,161
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,877

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See attached schedule	2,008
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,008

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1			$		$	$	$	$	$	$	$	$	$
2								N/A					
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN - $4,965**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **11.5 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **21,343** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **125,655**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **12,585**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit not yet completed.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees